STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155295	B. WING		02/06/2013
NAME OF P	ROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP CODE	
CLINTON	I HOUSE HEALTH	AND REHAB CENTER		V FREEMAN ST IKFORT, IN 46041	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	•	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE
F0000	112002.11011101	Case in the first of the state	1110		3.112
F0000	State Licensurincluded the In Complaint INO Complaint INO unsubstantiate evidence. Survey dates: 31, February 1 facility number Provider number AIM number: Survey team: Rita Mullen, R Michelle Carte Census bed ty SNF/NF: 72 Total: 72 Census payor Medicare: 17 Medicaid: 47 Other: 8 Total: 72 These deficier	0121605. 0121605 ed, due to lack of January 28, 29, 30, , 4, 5 and 6, 2013. :: 000192 per: 155295 100291120 N, TC r, RN pe:	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 02/26/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155295	A. BUILDING B. WING	00	COMPLETED 02/06/2013
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE FREEMAN ST	
CLINTON		AND REHAB CENTER	FRANK	FORT, IN 46041	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
IAG	Quality Review	completed by Tammy bruary 12, 2013.	IAG		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: K30C11

Facility ID: 000192

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155295	A. BUILI B. WING			02/06/	2013
			p. white		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIE	R			FREEMAN ST		
CLINTON	N HOUSE HEALTH	I AND REHAB CENTER			FORT, IN 46041		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL	l l	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG F0248		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
SS=D	EACH RES The facility must program of activ	er interests/needs of provide for an ongoing ities designed to meet, in the comprehensive					
		interests and the physical, chosocial well-being of each					
	Based on reco	ord review and	F024	-8	Resident # 82 ha	S	03/08/2013
	interview, the	facility failed to ensure			been assessed and		
	an activity pla	n was offered for 1 of 3					
	residents revie	ewed for activity			found to have no		
		n a sample of 3.			adverse effects from		
	(Resident #82	•			alleged deficient		
	Findings inclu	,			practice. Residents who a		
		eart for Resident #82 on 2/05/12 at 1:50 P.M.			to have 1:1 for activiting the have the potential to affected by the allege	be	
	limited to, qua	luded, but were not driplegia, high blood hypothyroidism.			deficient practice. Activity records we be audited and		
	on 1/29/13 at that he does r	rview with Resident #82 1:18 P.M., he indicated not participate in to spending most of his			residents on 1:1 will be interviewed by the Activity Director to ensure activities are being scheduled as p		
	Activity Director P.M. She indireceived 1 on	vas conducted with the or on 2/05/13, at 3:05 cated Resident #82 1 interaction due to the ot like to get out of his			care plan.Activity personnel will be in serviced on appropria activities for those residents who may	ate	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155295	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/06/2013
		100290	B. WING		02/00/2013
	PROVIDER OR SUPPLIER	AND REHAB CENTER	809 W	ADDRESS, CITY, STATE, ZIP CODE FREEMAN ST (FORT, IN 46041	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N BE COMPLETION
	bed very often. Activity particip	pation calendars for		require 1:1 activities.Activity	
	January and F	ebruary 2013 indicated received the following		Director will audit records of those	
		director and resident)		residents who requi	
		nd sensory programent event activities,		1:1 activities 3 times week for 4 weeks, t	
	social visits, re	miniscing, and food scussion. These		weekly for 4 weeks,	
	activities occur	red 1 to 3 times per		then monthly for 4 months. Non	
	week for the tir 2/5/13.	ne period of 1/16/13 to		compliance will be	
	on the following 1/16/13, 1/21/1 1/25/13, 1/29/1 2/5/13. An Activity care indicated resid 1 services 2-3 as paper article music, and /or Activity notes, indicated "resid"	3, 1/22/13, 1/23/13, 3, 1/30/13, 2/4/13, and e plan, dated 10/03/12, ent was to receive 1 on times per week, such es, current events, sensory program.		addressed through re-education and/or progressive disciplinations as indicated. Results will be reviewed monthly in meeting times 6 months and then quarterly subsequent plan development and implementation as appropriate.	nary I. n QA onths
	Director on 2/5 indicated the reany activity ser	view with the Activity /13 at 3:20 P.M., she esident did not receive vices from the time of 3/12) to 1/16/2013			

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155295	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMI	E SURVEY PLETED 6/2013
	PROVIDER OR SUPPLIER N HOUSE HEALTH AND REHAB CENTER	809 W I	ADDRESS, CITY, STATE, ZIP CO FREEMAN ST FORT, IN 46041	DDE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	because he indicated he did not wish to participate in activities. Supporting documentation of the refusal of activities was not provided by the facility staff. 3.1-33(a)				

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Event ID: K30C11

Facility ID: 000192

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED 02/06/2013	
		155295	B. WIN			02/06/2	2013
NAME OF P	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE FREEMAN ST		
CLINTON	N HOUSE HEALTH	AND REHAB CENTER			FORT, IN 46041		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
F0282	483.20(k)(3)(ii)	LSC IDENTIFTING INFORMATION)		TAG			DATE
SS=D	SERVICES BY CONTROL CARE PLAN The services provided facility must be provided by the services are services.	UALIFIED PERSONS/PER vided or arranged by the rovided by qualified dance with each resident's					
	written plan of ca	re.					
	Based on reco		F02	82	Residents # 82 a	nd	03/08/2013
		acility failed to follow			31 have been assess	ed	
		re plan for 1 of 3			and found to have no		
		wed for activity care It #82) and failed to			adverse affects from		
	ensure a physi	,			alleged deficient		
		of 1 residents reviewed			practice.		
		vices. (Resident #31)			Residents who ar		
	ĺ	,				-	
	Findings includ	le:			to be provided 1:1		
					activities and those		
		chart for Resident #82			residents who have		
	was reviewed of	on 2/05/12 at 1:50 P.M.			orders for fluid		
					restrictions have the		
	-	uded, but were not			potential to be affecte	d	
		driplegia, high blood hypothyroidism.			by the alleged deficie	nt	
	pressure, and i	Typotityroidistii.			practice.		
	During an inter	view with Resident #82			Activity records w	ill	
	_	:18 P.M., he indicated			be audited and		
	that he does no	· · · · · · · · · · · · · · · · · · ·			residents on 1:1 will b	e l	
	activities due to	spending most of his			interviewed by the		
	time in bed.				Activity Director to		
					ensure activities are		
	•	e plan dated 10/03/12,				or	
		esident was to receive			being scheduled as p	er	
		s, 2-3 times per week,			care plan.Medical		
		articles, current			records of residents of		
	events, music,	and /or sensory			fluid restrictions will b	e l	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SI		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155295	B. WIN			02/06/2	:013
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
CLINTO	N HOUSE HEALTH	AND REHAB CENTER	809 W FREEMAN ST FRANKFORT, IN 46041				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	,	DATE
	program.				reviewed by the DON	/or	
	An interview w	as conducted with the			designee to ensure		
		or on 2/05/13, at 3:05			intakes and outputs a		
	P.M., She indi	cated Resident #82			being recorded prope	· 1	
	received 1 on	1 activity interaction			and separate from for	od	
		he does not like to get			consumption.Activity		
	out of his bed	very often.			personnel will be in		
	Activity particir	pation calendars for			serviced on appropria	ate	
		ebruary 2013 indicated			activities for those		
	1	eceived the following 1			residents who may		
		irector and resident)			require 1:1 activities.		
	visits: music a	nd sensory program			Licensed nursing staf	f	
		ent event activities,			will be in serviced on		
		miniscing, and food			fluid restrictions and		
		scussion. These red 1 to 3 times per			policy and procedure	of	
		me period of 1/16/13 to			documentation of		
	2/5/13.				intakes and outputs,		
					and following		
		eceived an activity visit			physician's orders.		
	on the followin				Dialysis "folders" have	е	
		13, 1/22/13, 1/23/13, 13, 1/30/13, 2/4/13, and			been implemented to		
	2/5/13, 1/29/1 2/5/13.	13, 1/30/13, 2/4/13, and			ensure documentation	n	
	2/0/10:				on residents who hav	е	
	Activity notes,	dated 10/3/12,			dialysis offsite. Activi	ty	
		dent to receive 1:1 [one			Director will audit		
	on one service	s], 2 - 3 times weekly."			records of those		
	During as inte-	nious with the Astinity			residents who require	,	
		view with the Activity 6/13 at 3:20 P.M., she			1:1 activities 3 times a		
		esident did not receive			week for 4 weeks, the		
		rvices from the time of					

	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
	155295	A. BUILDING B. WING		02/06/2013
			ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER		FREEMAN ST	
CLINTO	N HOUSE HEALTH AND REHAB CENTER	FRANK	(FORT, IN 46041	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
1110	admission (10/3/12) to 1/16/2013	0	weekly for 4 weeks,	5.112
	because he indicated he did not wish		then monthly for 4	
	to participate in activities. Supporting		months. Non	
	documentation of the refusal of		compliance will be	
	activities was not provided by the		addressed through	
	facility staff. The Activity Director indicated she reviewed Resident		re-education and/or	
	#82's care plan for activities and was		progressive disciplina	arv
	aware the care plan was not followed.		actions as indicated.	al y
	·		The director of nursing	ng
			or designee will audit	· 1
			the medical records of	
			those on intake and	וי
			output monitoring 3	
			times a week for 4	,
			weeks, 1 time a week	
			for 4 weeks, and onc	
			week for 4 months. N	ion
			compliance will be	
			addressed through	
			re-education and/or	
			progressive disciplina	ary
			actions as indicated.	
			Results will be	
			reviewed monthly in (
			meeting times 6 mon	
			and then quarterly wi	th
			subsequent plan	
			development and	
			implementation as	
			appropriate.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155295	B. WIN	G		02/06/2013	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CLINITON	LUQUEEUEALTU	AND DELIAD CENTED			FREEMAN ST		
		AND REHAB CENTER			FORT, IN 46041		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5	
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLE DATE	
1710		record of Resident #31		mo	<u> </u>	DATE	
		on 1/30/13 at 10:30					
	A.M.	311 17007 10 at 10.00					
	, .						
	Diagnoses incl	uded, but were not					
	_	stage renal disease,					
		as receiving dialysis					
	three times a w	veek outside the					
	facility.						
	_	view with Resident					
	· ·	3 at 9:37 A.M., she					
		cept drinks in her					
	refrigerator in h	ier room.					
	Δ Dialveis Care	e Plan, dated 11/24/12,					
		Resident had acute					
		ould be free of fluid					
	· ·	vould receive a diet as					
	ordered.						
	A Physicians o	rder, dated 11/24/12,					
	indicated "cont	inue to monitor fluid					
		fluid restriction, 1 qt					
	per day."						
		daily fluid distribution					
		the taking of oral					
	medications wa	as as tollows:					
	"1 qt per day F	luid Restriction					
	i qiperday F	านเน เงองแบบเบเ					
	120cc (cubic m	nillimeters) 10p-6a,					
	,	20cc 2p-10p Nursing					
	1					1	

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	TO F DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155295	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/06/2013
	PROVIDER OR SUPPLIER N HOUSE HEALTH AND REHAB CENTER	809 W F	ADDRESS, CITY, STATE, ZIP CODE FREEMAN ST FORT, IN 46041	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	240cc Breakfast, 120cc Lunch, 120cc Dinner Dietary."			
	A review of the resident intake records for Resident #31, on 1/30/13 at 10:35 A.M., indicated the total percentage of meals consumed but not the amount of fluids drank during meals.			
	During an interview with LPN #1, on 2/5/13 at 2:00 P.M., she indicated the meal intake is monitored but the fluids aren't monitored separately.			
	3.1-35(g)(2)			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155295	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/06/2013
	PROVIDER OR SUPPLIER	AND REHAB CENTER	STREET A	ADDRESS, CITY, STATE, ZIP CODE FREEMAN ST (FORT, IN 46041	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
F0329 SS=D	from unnecessary drug is any drug of dose (including dose (including dose (including dose (including) of the excessive duration monitoring; or with for its use; or in the consequences which should be reduce combinations of the esident, the facilities are not given antipsychotic drug treat a specific condocumented in the residents who use receive gradual dose behavioral intervec contraindicated, in these drugs. Based on reconsinterview, the fact the effectivenemedications for reviewed for unmedications. (34) Findings included.	DRUGS rug regimen must be free y drugs. An unnecessary when used in excessive uplicate therapy); or for n; or without adequate hout adequate indications ne presence of adverse nich indicate the dose d or discontinued; or any he reasons above. Inchensive assessment of a fity must ensure that we not used antipsychotic en these drugs unless g therapy is necessary to indition as diagnosed and e clinical record; and e antipsychotic drugs ose reductions, and entions, unless clinically in an effort to discontinue and review and accility failed to assess as of PRN (as needed) in 3 of 10 residents innecessary Residents #16, 31 and	F0329	Residents # 16, 3 and 34 have been assessed by licensed nurse to ensure there have been no adverse affects from alleged deficient practice. Residents who receive PRN medications have the potential to be effected.	e

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLETED
		155295	B. WIN			02/06/2013
NAME OF I				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	· ·		809 W	FREEMAN ST	
		AND REHAB CENTER			(FORT, IN 46041	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	*	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
TAG	A review of the	<u> </u>		TAG	,	
					by this alleged deficie	ent
		Records (MAR) for the cember 2012 and			practice	
		indicated the following:			 Licensed nursing 	
	January 2013	indicated the following.			staff will be in service	d
	December 201	2: Resident #16			on standards of	
	received a PR	N medication 16 times.			practice, assessment	s,
		essed by a nurse as to			and follow up when	
	the effectivene				giving PRN	
		d fourteen PRN			medications. Qualifie	ed l
		ere not assessed for			medication aides will	
	effectiveness.				in serviced on	
	January 2012:	Decident #16 received				nt
	1	Resident #16 received tion 28 times. Five			requesting assessme	
		by a nurse as to the			from licensed nurse for	
		of the PRN medication			giving PRN medication	ns
		ee PRN medications			and follow up	
	1	ssed for effectiveness.			documentation by the	!
					licensed nurse.	
	2. The clinical	record of Resident #31			Director of nursing or	ſ
	was reviewed	on 2/5/13 at 2:30 P.M.			designee will monitor	
		NA 12 C			the 24 hour report	
	A review of the				sheet for PRN	
		Records (MAR) for the			medications and	
		cember 2012, January ruary 1 through 4, 2013			appropriate follow up	
	indicated the fo	•			documentation 5 time	.
		Jilowing.				
	December 201	2: Resident #31			a week for 4 weeks, 3	5
		N medication 42 times.			times a week for 4	
		ere assessed by a			weeks, once a week t	for
	,	e effectiveness of the			4 weeks, then monthl	y
		on and thirteen PRN			for 3 months. Non	
		ere not assessed for				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILDING 00		COMPLETED	
	155295		B. WING			02/06/2013	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			FREEMAN ST		
CLINTON HOUSE HEALTH AND REHAB CENTER			FRANKFORT, IN 46041				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORR			
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE C	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	effectiveness. January 2013: Resident #31 received a PRN medication 43 times. Twenty				compliance will be		
				addressed through			
					re-education and/or		
	nine were assessed by a nurse as to			progressive disciplinary			
	the effectiveness of the PRN			actions as indicated.			
	medication and fourteen PRN			Results will be			
	medications were not assessed for				reviewed monthly in C) AC	
	effectiveness.				•		
	Silodivoridos.				meeting times 6 months		
	February 1, 2, 3 and 4, 2013: Resident #31 received a PRN				and then quarterly wit	n	
					subsequent plan		
	medication 18 times. Seven were				development and		
					implementation as		
	assessed by a nurse for effectiveness				•		
	of the PRN medication and eleven were not assessed for effectiveness. A Policy for "Medication Administration Operating Standard Guideline," dated December 2012, received from the Director of Nursing, on 2/6/13 at 9:50 A.M., indicated the following: "PRN medications-Given upon request or administered per body language or behavior. Document				appropriate.		
	reason and follow up results on back						
	of MAR"						
	3. The clinical record of Resident #34 was reviewed on 2/5/13 at 1:00 P.M.						
	A review of the Medication						
7 TO VIOW OF THE INICATOR OF			1				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING	00		LETED				
		155295	B. WING			5/2013			
	PROVIDER OR SUPPLIER	AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 809 W FREEMAN ST FRANKFORT, IN 46041						
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) Records (MAR) for the	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE			
TAG	Administration month of Janu PRN medication 1/23/13 at 7:16 There was no	Records (MAR) for the lary 2013 indicated a lon was given on 3 P.M., by QMA #2. Inursing note as to the lof the PRN medication.	TAG	DEFICIENCY)		DATE			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: K30C11

Facility ID: 000192

If continuation sheet

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